

Healthy Children: Health Care Coverage and Access for King County's Low-Income Kids

Children's Health Access Task Force Final Report

August 2006





King County Children's Health Access Task Force Membership

Co-Chairs

Maxine Hayes, M.D., MPH, State Health Officer Washington State Department of Health

Benjamin Danielson, M.D., Medical Director Odessa Brown Children's Clinic

Task Force Members

Dale Ahlskog, Executive Director
Molina Healthcare of Washington

Teresita Batayola, Executive Director International Community Health Services

Jane Beyer, Senior Counsel Democratic Caucus Staff Washington State House of Representatives

Chris Bushnell, Economist King County Budget Office

Bob Cowan, Budget Director King County Budget Office

Laura Cox, Project Associate
Center on Budget and Policy Priorities

Bob Crittenden, M.D., Chief, Department of Family Medicine

Harborview Medical Center

Darnell Dent, President and CEO Community Health Plan of Washington

Charissa Fotinos, M.D., Medical Director Public Health, Seattle & King County

Christina Hulet, Executive Policy Advisor Governor's Executive Policy Office, State of Washington

Tracy Garland, President and CEO Washington Dental Service Foundation

Claudia Sanders, Vice President, Policy Development Washington State Hospital Association

Paola Maranan, Executive Director Children's Alliance

Suzanne Petersen, Director of Government Affairs Children's Hospital and Medical Center

Dorothy Teeter, Interim Director and Health Officer Public Health – Seattle & King County

Greg Vigdor, President and CEO Washington Health Foundation

Staff to the Task Force

Judith Clegg, President Clegg and Associates

Susan Johnson, Director, King County Health Action Plan

Public Health – Seattle & King County

Marcy Maurer, Assistant Division Manager, Community Health Services

Public Health – Seattle & King County

Rachel Quinn, Health Policy Analyst

Office of King County Executive Ron Sims

Kirsten Wysen, Policy Analyst

Public Health – Seattle & King County

Additional Participants

John Amos

King County Budget Office

Liz Arjun

Children's Alliance

Tim Barclay

Milliman Consultants and Actuaries

Jerry DeGrieck

City of Seattle

Paula Holmes

Odessa Brown Children's Clinic

Rebecca Kavoussi

Community Health Plan of Washington

Jonathan Larson

King County Budget Office

Desiree Leigh

Children's Hospital

Pam MacEwan

Group Health Cooperative

Erika Nuerenberg

Office of King County Council Member Julia Patterson

Lisa Podell

Public Health-Seattle & King County

Penny Reid

Washington Health Foundation

Laura Smith

Washington Dental Foundation

Melissa Waddell

Washington State Hospital Association

Hall Walker

King County Budget Office

For more information on King County's Child Health Initiative:

Please contact Rachel Quinn at (206) 296-4615 or rachel.quinn@metrokc.gov, or Susan Johnson at (206) 296-4669, susan.johnson@metrokc.gov.

Additional information can be found on the web, at: www.metrokc.gov/exec/chatf





August 2006

King County Executive Ron Sims 701 Fifth Ave. Suite 3210 Seattle, WA 98104

Dear Executive Sims,

It has been an honor to co-chair the King County Children's Health Access Task Force from April to June 2006. Thank you for this opportunity to serve, and for your incredible vision and energy. We are especially proud that King County is taking a pro-active stance on this issue of providing better healthcare and dental care to children from low-income families.

With this letter we are transmitting the recommendations of the Task Force, which advises you to expand access and outreach activities for health care coverage immediately, and to create a Children's Health Initiative that will offer health coverage to children in low-income families in King County who are not eligible for state or federal programs. For Phase 1, in the remainder of 2006, we recommend targeting outreach to families who are currently uninsured yet eligible for state and federal health insurance programs. In Phase 2 in early 2007, we recommend launching a new health and dental coverage program for children in low-income and working poor families with incomes up to 300 percent of the federal poverty level. By 2010, we will reach a Phase 3 where the state achieves its pledge to cover all children in Washington State.

Bringing health care coverage and access to needed services to low-income King County children is the *Right Cause*, for the *Right Reasons*; it is on the *Right Scale* and solutions are needed *Right Now*. We need to start making smarter investments in health care services. It would be difficult to find anyone who would say that today's status quo healthcare is adequate or acceptable. Our current system often leads to the highest possible costs by failing to promote prevention or lower cost early interventions. The health burden of uninsured and under-insured children in King County is a burden that all of us bear in more ways than might be appreciated.

Bringing health care coverage and access to needed services to low-income King County children in this program is an opportunity to turn the page in King County. We have good reference models and lessons learned from some similar piloting efforts in counties in other states. Local expertise has been brought together in an energetic task force with a comprehensive knowledge of the healthcare system.

The scope of this program is appropriate because in King County we are addressing the health needs of a manageable number of children. This provides for a logistically efficient model to pilot health coverage solutions. This size program is more easily feathered into the existing healthcare system without disrupting other forms of coverage or services. Manageable scope also allows for accurate measurement and tracking of its effectiveness. This is especially important as it informs larger statewide strategies in accord with Governor Gregoire's 2010 goal to cover all children in Washington.

Once again, we were honored to serve as co-chairs of the King County Children's Health Access Task Force, and we and the rest of the Task Force are ready to work with you to assure that we do the best we can for our children's health. We close this letter with the quote you used in the "State of the County" address on May 22, 2006 when you spoke of your commitment to children's health:

Many things we need can wait. The child cannot. Now is the time his bones are being formed, his blood is being made, his mind is being developed. To him we cannot say tomorrow, his name is today.

-Gabriela Mistral, Chilean poet, 1889-1957

With appreciation,

Marine Hayes, M.D., MPH

State Health Officer

Washington State Department of Health

Benjamin Danielson, M.D.

Medical Director

Odessa Brown Children's Clinic

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EXECUTIVE SUMMARY

An estimated 16,000 children living in King County (4%) have no health insurance, according to 2004 survey data. About half of these 16,000 uninsured children are eligible for existing publicly-funded insurance programs. After Public Health-Seattle & King County (PHSKC) conducted an internal study on uninsured low-income children in King County, County Executive Ron Sims concluded that the County has a unique opportunity. In partnership with the State of Washington, which has declared its intention to cover all children in the state by 2010, the County has begun work to design an innovative program to provide health and dental insurance coverage and access to a medical home – a regular source of healthcare that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective – for most of the 16,000 children uninsured in King County.

To make a difference in children's health, it is essential to have both health care coverage and a health care delivery system that is ready to provide early preventive services and link children to needed care. Recognizing this dynamic, in April 2006, King County Executive Sims convened a Children's Health Access Task Force (CHATF) of child health experts to advise King County on the creation of an innovative county-based children's health program. Dr. Maxine Hayes, the Washington State Health Officer, and Dr. Ben Danielson, the Medical Director at Odessa Brown Children's Clinic, co-chaired the Task Force, with support from Milliman consultants and actuaries who carried out actuarial and programmatic analyses of various program designs. The Task Force met three times between April and June 2006 and recommended the creation of a program that will dovetail with the State's 2010 goal and build on the innovative work of the King County Health Action Plan, such as the Kids Get Care program.

Task Force Recommendations

The Task Force recommends a phased approach to improving the health of low-income children, starting with an outreach and access phase in 2006, followed in 2007 by a health insurance program to fill in the "gap" left by current public coverage programs and culminating in 2010 with full statewide coverage.

<u>Phase 1: Outreach and Access Improvement</u>: The Task Force recommends investing funds to identify and sign up the estimated 8,000 low-income children eligible for existing publicly funded insurance programs by implementing a targeted access and outreach program, and connecting families to comprehensive preventive services including oral and mental health and a medical home.

<u>Phase 2: "Gap" Insurance Program for Children:</u> The Task Force recommends creating a basic gap medical and dental insurance program that would be offered to an estimated 5,000 children in families under 300 percent of the federal poverty level or children who are not eligible for existing public or private programs. These programs will be similar to existing publicly-funded health programs in terms of benefits, eligibility and cost, and have minimal cost sharing.

<u>Phase 3: Consolidation with State Programs in 2010:</u> Governor Gregoire has set a goal for the State of Washington that all children in the state will be covered by health insurance by 2010. By 2010, the King County program should either be consolidated into the state's coverage programs or the state should provide the financial resources to King County to continue this program as a component of the state's overall strategy.

In addition, the Task Force recommends King County aggressively seek partners and funding opportunities, conduct a comprehensive evaluation of the initiative, coordinate efforts with the State of Washington's child health expansion efforts, and employ strategies that reward quality and efficiency that align with the goals of prevention and overall improved health status.

As next steps, the Task Force proposes that Task Force staff continue to finalize the programmatic and financial information necessary to move the proposed program through King County's decision process with the King County Council and to explore funding partnerships with foundations and private organizations. Concurrently, the Task Force recommends that two committees be established to steer the implementation process—an Outreach Committee, and an Operations and Policy Committee – to guide outreach strategies and provide general oversight and guidance, respectively, As the committees develop an implementation strategy, the Task Force strongly recommends they adopt innovative program design features and reimbursement strategies that promote the use of incentives to improve health status and align with the work of the Puget Sound Health Alliance.

BACKGROUND

An estimated 16,000 children in King County (4%) have no health insurance, according to 2004 survey data. About half of these 16,000 uninsured children are eligible for existing programs: Medicaid, Washington State Children's Health Insurance Program (SCHIP) or Basic Health Plan (BHP) coverage. Medicaid covers about 460,000 children statewide below 200 percent of the federal poverty level (FPL). SCHIP covers about 11,000 children statewide from 200 percent to 250 percent of the FPL, and excludes immigrant children. Basic Health covers about 15,000 children living in Washington up to 200 percent of the FPL, with limited benefits, e.g. no dental or physical therapy, and substantial cost sharing.

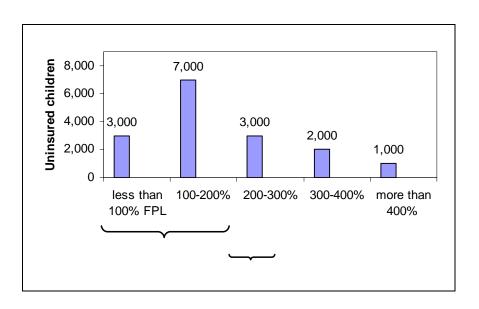


Chart 1. Uninsured children by family income level in King County, 2004

Consequences of being uninsured and access to care barriers

Data show that uninsured children have less access to health care, are less likely to have a regular source of primary care or medical home and use medical and dental care less often compared to children who have insurance. Data also show that access to early preventive health care services can profoundly improve the trajectory of a child's health and well-being and readiness for school. Undiagnosed and untreated conditions that are amenable to control, cure, or prevention can affect

children's functioning and opportunities over the course of their lives. Even with presence of health insurance such as Medicaid coverage, access to proper health and dental services may be difficult. For example, only 31 percent of King County children under age six with Medicaid received any dental services in 2004. Access improvement programs, such as the Access to Baby and Child Dentistry (ABCD), have worked with physicians, dentists and public health departments to increase the percentage of children receiving early preventive dental care. For more examples and citations, please see the feasibility study conducted by Public Health-Seattle & King County (PHSKC) in Appendix A.

Costs of the uninsured

The real costs of uninsured children far exceed the costs of providing coverage because children without health insurance eventually receive care from emergency rooms or other safety net providers, where the cost of care is often greater than it would have been if these children had received preventive care or early treatment for a health problem. Children's Hospital & Medical Center in Seattle provided \$7.5 million or 2.1 percent of revenue in charity care in 2005. The Public Health-Seattle & King County clinics provided about 3,000 primary care visits to 1,900 uninsured children in 2005 at a cost of approximately \$550,000. The community health centers in King County bear a higher financial burden; they provided care to an additional 7,000 to 9,000 uninsured children in 2005.

Improving Access and Coverage for Children

Insured children have better access to a medical home or regular source of care, and through medical homes have better access to appropriate and timely prevention, detection and care. The California Health Status Assessment Project found that children who were enrolled in health insurance improved their school performance ("paying attention in class" and "keeping up with the school activities") by 68 percent. Improved access and coverage also brings savings. In San Mateo County, California, the Child Health Initiative program was associated with a 58 percent decline in uninsured hospital stays for children in nearby hospitals.

CHILDREN'S HEALTH ACCESS TASK FORCE & ITS CHARGE

To make a difference in children's health, it is essential to have both health care coverage and a health care delivery system that is ready to provide early preventive services and link children to needed care. This is a key lesson learned as states such as Vermont and California have embarked on initiatives to improve the health of children. King County has a unique opportunity to create a program to extend coverage and access to low-income children currently without health insurance in partnership with the State of Washington, which has declared an intention to cover all children in the state by 2010.

To explore the potential of such a program, King County Executive Sims called upon PHSKC to conduct a feasibility study to analyze the costs, potential savings, potential revenue sources, benefit package modeling, delivery system linkages and enhanced prevention services necessary to pilot an expansion of health coverage and access to all low-income children living in King County with incomes up to 300 percent of the FPL. That work was completed in the spring of 2006 (see Appendix A for Feasibility Study).

In April 2006, following review of the feasibility study findings, King County Executive Sims convened a Children's Health Access Task Force (CHATF) of child health experts to advise King County on the creation of an innovative county-based children's health program. (See Appendix B for invitation letter from Executive Sims). Dr. Maxine Hayes, the Washington State Health Officer, and Dr. Ben Danielson, the Medical Director at Odessa Brown Children's Clinic co-chaired the Task Force. The Task Force's work was supported by Milliman Consultants and Actuaries who carried out actuarial analyses of various program designs and by staff from the Office of King County Executive and the King County Health Action Plan (PHSKC), an existing coalition of public and private health care delivery system representatives, several of whom served on the Task Force.

The Task Force was asked to consider the feasibility study and to respond to the Executive's goals for a King County children's health program that would:

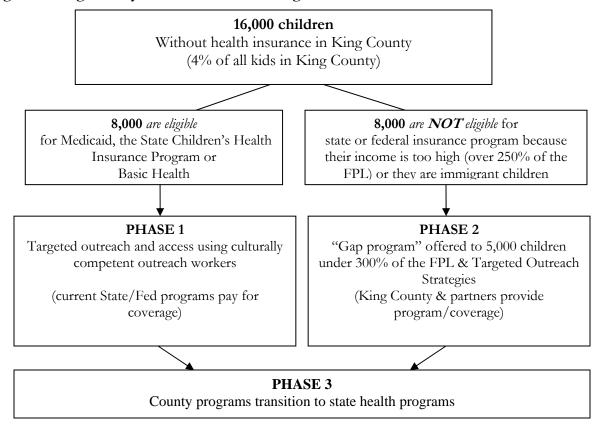
- Create an innovative program that can fill the existing gap in coverage for low-income children
- Design and implement a model program that will expand coverage and improve access on a cost effective basis

The Task Force has now completed its work and what follows are their recommendations.

RECOMMENDATIONS

The Task Force recommends that King County implement a phased in approach to improving the health of low-income children, starting with an outreach and access phase in 2006 and following in 2007 with a health insurance program to fill in the "gap" left by current public coverage programs (see Figure 1 below). A third phase will ensue as the County program transitions into the state children's coverage expansions.

Figure 1. King County's Child Health Coverage



Phase 1: Outreach and Access Improvement Elements

The Task Force recommends investing funds to identify low-income children eligible for existing publicly funded insurance programs by implementing a targeted access and outreach program, beginning in Fall 2006. Strategies include funding new outreach staff and community health workers who are trusted communicators to help sign up the estimated 8,000 children for the coverage they qualify for, and to connect them to comprehensive preventive services including oral and mental health and a medical home. This investment is projected to connect the majority of children eligible for Medicaid and SCHIP to a medical home and health insurance.

Also included in Phase 1 are the start up costs of the gap insurance program, including hiring a program manager, writing a request for proposals for health plans to cover children in 2007, funding for a rigorous evaluation, and establishing operational expertise for processing applications from families.

Phase 2: "Gap" Insurance Program for Children

Beginning in 2007, the Task Force recommends creating a gap insurance program that would be offered to 5,000 children in families under 300 percent of the FPL or children who are not eligible for existing public or private programs. Children in families over 300 percent of the FPL are not eligible for this gap insurance program. Final enrollment targets will be determined by the level of funding available to the new program.

The Task Force recommends that the new King County gap coverage program offer similar health and dental benefits as Washington State's Healthy Options (Medicaid) benefits for children in families with incomes up to 300 percent of the FPL (\$49,800 for a family of three, \$60,000 for a family of four). Cost sharing is imposed for families with incomes between 200 and 300 percent of the FPL but not for families with incomes below 200 percent of the FPL, except for a modest copayment for brand name prescription drugs. As program staff talk to families about the new program, it is expected that they will find an equal or larger number of families eligible for current coverage programs.

Details about the access improvement elements, eligibility, benefits, and cost sharing levels recommended by the Task Force follow in tabular format, starting on page 9. The estimated actuarial costs of the medical and dental program models are as follows:

Proposed Medical and Dental Benefit Plans for King County Gap Insurance Program	Per Member Per Month Net Claim Cost
Medical benefit plan for children 200 – 300 percent of FPL	\$76.38
Medical benefit plan for children below 200 percent of FPL	\$84.28
Dental benefit plan for children under 300 percent of FPL	\$28.03

For Milliman's detailed actuarial analysis see Appendix C.

Related to Phase 1 and Phase 2, the Task Force recommends a number of general programmatic components be employed:

- Seek partners and funding opportunities. King County should partner with the State of Washington and should aggressively solicit financial support from local and national private organizations and foundations. The recommended three-phase approach will not succeed without the involvement and support of local stakeholders. When implemented, these three phases will provide immeasurable benefits to uninsured and underinsured children as well as the entire King County community.
- Coordinate and collaborate with the Governor's Office and State. King County should
 work closely with the Governor's Office and the State of Washington to ensure that the county's
 program will segue effectively into the upcoming state initiative. Child health will only make
 significant improvements if local, state and national efforts and strategies are coordinated and
 complement, not conflict, with each other.
- Conduct a comprehensive evaluation of Phases 1 and 2. King County's Children's Health Initiative should dedicate sufficient resources and funds to conduct a comprehensive evaluation of the different programmatic components. Being able to demonstrate improvement based on performance assessment will be a necessity for the phased approach to maximize its operational

effectiveness and stay within budget. Equally important, performance and outcome results will inform the State's effort as it develops its strategy to cover all kids in 2010. For example, potential performance measures of success for Phase 1 would include the number of accepted applications for Medicaid, SCHIP and other publicly funded insurance, the number of new children with a regular source of medical and dental care, and the number of trained community agency staff e.g. child care workers. For Phase 2, promising measures include the number of new children with coverage, the number of new children with a regular source of medical and dental care, the number of children up-to-date with well child visits, the number of children up-to-date with immunizations, reductions in emergency room visits, reductions in unnecessary hospitalizations, reduced access barriers, and others.

• Employ strategies that reward quality and efficiency that align with the goals of prevention. King County's Children's Health Initiative, through its Policy Committee, should pursue connections with the Puget Sound Health Alliance to reward providers who provide preventive care and quality health care services to children that lead to improved health status. The Puget Sound Health Alliance is a regional nonprofit founded and led by the King County Executive and in which King County is a major participant, to improve the quality of health care in the Puget Sound region.

Phase 3: Consolidation with State Programs in 2010

In Phase 3, the King County children's coverage programs will segue into the state program expansions. By 2010, the King County program should either be consolidated into the state's coverage programs or the state should provide the financial resources to King County to continue this program as a component of the state's overall strategy.

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¹ The Alliance in December 2005 adopted the Institute of Medicine (IOM) starter set of measures. There are at least three dozen pediatric or child-related measures in the IOM starter set for pre-natal care, childbirth, neonatal care, childhood wellness and immunizations, childhood access to care, adolescent immunizations, pediatric asthma care, pediatric upper respiratory infection (URI) treatment, pediatric pharyngitis care, and parents' satisfaction with their children's health care.

Outreach and Access Improvement Elements

Purpose	Proposed Design	Goal
Phase 1: In the Commun. Elements	ity (Beginning Fall 2006): Outro	each and Access Improvement
	Outreach Teams Create four teams consisting of an application worker, community health worker and health educator Teams in each of four geographically targeted areas: • East King County • Seattle, White Center and North King County • South King County— Des Moines to Renton • South King County— Federal Way, Kent and Auburn	Increase coverage rates and early access to health care for low income populations in targeted areas as measured by increases in enrollees and children with medical and dental homes. Increase the focus on the advantages of prevention, especially among cultures in which preventive care is not accessed, to increase the rates of immunizations, well-child checks, developmental screening, early oral health exams, fluoride varnishes, and sealants. Find children eligible but not enrolled for current programs in '06, and for the new county gap program in '07 and assist with enrollment, linkage to a health care home, and navigating the health care system Provide culturally effective, tailored health messages in enrollees' first language when necessary (including translated materials). Additional target populations include at-risk
		populations include at-risk children such as homeless youth and those in detention centers Teach families and community staff who work with children about the benefits of preventive care

Phase 2: In the Clinic (Beginning 2007): Care Coordination and Behavioral Health

Link families to needed wrap around services and promote integrated preventive care

Care Coordination

Hire one Patient Care Coordinator per 2,000 children at one or multiple health care provider sites. Staff four sites in 2007 and, pending evaluation of the cost effectiveness of this model, seven sites in 2008.

Patient Care Coordinators provide a single point of contact for community agency staff and families. They assist with securing needed preventive care, chronic care, wrap around services, referrals, and follow-up care.

Care Coordinators can assist clinics to increase well child visits by 41%, oral health screens by 104% and developmental screenings 72-fold.

Eligibility and Benefits

	Proposed Design	Rationale		
Phase 2 (Jane	Phase 2 (January 2007): "Gap" Insurance Program for Children			
Age	Up to 19	Same as Medicaid and SCHIP		
Residency	King County residents	Same as California county programs		
Income	 Children in families between 200%-300% of FPL Family of 2: \$26,400 – \$39,600 Family of 3: \$33,200 - \$49,800 Family of 4: \$40,000 - \$60,000 Children not eligible for existing insurance programs due to immigration status (0-300% of FPL) 	All but one of the California county programs extend to 300%, Santa Clara County goes to 400%; the goal of the gap program is to provide insurance to lower-income middle-class families, not to subsidize those families who are able to afford employer-based coverage.		
Other	Uninsured children ineligible for other health care coverage			
Waiting period protection (the period of time during which must be uninsured before enrolling)	3 months	Los Angeles (CA) has 3 month waiting period. After 2 years there is very little evidence "crowd out," i.e. when enrollees drop private health insurance and the public program is thought of as "crowding out" private coverage (one out of 2,000 persons who applied previously had employer-based private coverage). San Mateo (CA) has 6 months. There is little evidence of crowd out from private insurance. New Jersey over the last 5 years has lowered their crowd out provision from 12 to 6 to 3 months because there has very little evidence of crowd out.		
Pre- existing condition waiting period	None for general population, but 9 months for transplants, lipid storage diseases, malignancy, hemophilia and congenital malformations	This provision is imposed so that the new gap program does not create an incentive for families living outside King County with severely ill children to move. The Task Force acknowledges that this provision is not		

	Proposed Design	Rationale
		consistent with the goal of expanding access and coverage to children, but feels the need to have this rule in place to keep premiums affordable and to retain the intention of expanding coverage to King County families.
		This provision will enable children to get routine care and treatment for common conditions like asthma, therefore making it attractive for children to join without putting the program in financial strain.
Medical	Same as Medicaid	
Dental	Same as fee-for-service Medical Assistance Administration (MAA); added Access to Baby and Child Dentistry cost additions	The ABCD Program, now in 25 WA counties, has been shown to be effective in increasing the number of young children receiving early preventive services On average, ABCD-trained dentists receive an additional 10-30% reimbursement for preventive services
Vision	Same as fee-for-service Medicaid	
Mental health	24 outpatient visits 30 inpatient days Comparable to Medicaid	Under Medicaid, enrollees receive up to 12 outpatient visits through their managed care plan and if they need further services these are obtained through the Regional Support Networks, (RSN), without standard visit or day limits. The RSNs have severely limited capacity to serve new patients, especially those with mild to moderate mental health conditions who do not qualify as severely emotionally disturbed. The Task Force felt that a 24 visit and 30 inpatient day benefit was comparable and probably slightly less comprehensive than Medicaid mental health coverage, but that it was affordable and would meet the needs of most families.
		The Task Force supports an innovative delivery side strategy placing behavioral health specialists in the clinic in order to increase access for children needing mild to moderate

	Proposed Design	Rationale
		mental health care—a need that is not adequately met by the RSNs.
Substance abuse services	Same as Medicaid or up to a specific dollar limit	

Proposed Cost Sharing Features

	Below 200% FPL	Between 200% - 300% FPL	Rationale
Monthly Premiums	No	\$15 per child per month, \$45 max per family A hardship fund for premium assistance also will be created.	 Medicaid does not have premiums. The families of these eligible children do not have the means to pay premiums. Between 200%-300% of FPL WA SCHIP program premium is \$15. Aligns with program goals of simplicity (as it is the same premium as SCHIP). It is a reasonable and affordable amount substantially lower than 5% of income for those families who are between 200-300% of FPL. A \$15 premium is typical for other children's health insurance programs for children of the same income. San Mateo (CA) has a \$6 premium per child per month for 200-250% and \$12 per child per month for 251-300%. Illinois is proposing a \$40 premium (\$80 max) for this income level.
Deductible	\$0	\$0	Medicaid & SCHIP do not have a deductible.
Preventive visits	\$0	\$0	Medicaid & SCHIP do not have copayments for preventive care. The Task Force wants to encourage preventive care, not discourage it.

	Below 200% FPL	Between 200% -	Rationale
Office visits	\$0	300% FPL \$15	Below 200% of FPL
copayments		Ψ13	 No copay currently exists under Medicaid/Healthy Options. Copayments lead to poorer health for those with low incomes (low incomes = below 200% FPL). Among low-income adults and children, health status was considerably worse for those who had to make copayments than for those who did not (RAND study). Between 200%-300% of FPL The Task Force believes lower-income middle class families above 250% of FPL have the means to afford a modest copayment for office visits. A \$5 and \$10 copayment was dismissed because the administrative costs to process the payment are almost as high as the copayment amount.
Outpatient, radiology, lab, etc.	\$0	\$0	Medicaid & SCHIP do not charge copayments for outpatient, radiology, etc.
Inpatient hospital	\$ O	\$0	Medicaid & SCHIP do not charge copayments for inpatient hospital visits.
Emergency room visit	\$0	\$25	 No copay currently exists under Medicaid/Healthy Options. A \$5 or modest ER copay was dismissed due to the administrative costs to process the payment. Between 200%-300% of FPL The Task Force overall recommended a modest ER copay to encourage preventive care and appropriate ER use.

	Below 200% FPL	Between 200% - 300% FPL	Rationale
Prescription drugs	\$0 generics;	\$0 generics;	The Task Force advises a \$0 copay on generics and modest copay on brand name drugs to incent
urugs	\$10 brand name	\$10 brand name	use of generics.

PROPOSED IMPLEMENTATION PLAN

The Task Force has provided the framework for a comprehensive program that will bring health care to thousands of children in King County. Now that the framework is complete, the Task Force recommends that PHSKC staff begin to plan the implementation process described below. The goal is to have the program ready to go once the final policy and funding decisions are made. The Task Force recognizes that this report is a recommendation to the King County Executive and that implementation requires legislative and budgetary action by the Executive and the King County Council. Therefore, while the Task Force strongly recommends that King County implement the program in accordance with the framework described in the report, we understand that the Executive and the Council may need to adjust certain elements or the timeline as the program is enacted.

Phase 1: October – December 2006

Identifying Children Eligible for Existing Programs

Successful implementation of the enhanced outreach and access component of the system calls for staff work to proceed with program design tasks. To bring eligible children into existing health insurance programs during fall and early winter of 2006, PHSKC will convene an Outreach Committee in the summer to begin collaborating with staff on implementation planning for the Access Improvement design. The Committee will assist in determining the most effective methods for:

- Identifying the optimal locations for community health educators, community health workers,
 and outreach workers
- Establishing the necessary connections with community health providers, Department of Social
 and Health Services staff, social service agencies, and other entities that serve families

- Determining the appropriate sequencing for adding outreach and access capacity
- Developing evaluation criteria and outcome measures that will be used to assess effectiveness for the Access Improvement component.

Designing Program Operations

The program design for Phase 1 calls for both locating and enrolling children in existing health coverage programs for which they are eligible. The Access Improvement efforts outlined above will identify these children and the actual enrollment of eligible children into these programs must follow as the next step. In addition to the enrollment process, there are a variety of other operational issues to address in order to move forward with Phase 1, including turning the Task Force's recommendations into an operational plan, writing a request for proposals for the health plans that will cover uninsured children in Phase 2, preparing pre-launch promotional activities, collecting baseline evaluation data, and establishing administrative procedures for handling applications.

Phase 2: Coverage and Improved Access for Low-Income Children - January 2007

Identifying Children for the New Program

Running parallel to its work on Phase 1, the Outreach Committee will begin work on elements that are essential for the successful roll-out of Phase 2. While much of the Committee's Phase 1 access improvement work will carry over to Phase 2, additional issues and general guidance will need to be addressed in order to identify children eligible for enrollment in the county's new health insurance program. For example, the Committee will assist in designing methods to address the following issues:

 Linking the program implementation for children involved in Phase 1 of the program to the additional children obtaining coverage during Phase 2 Defining the outcome measures that will assess the effectiveness of the Phase 2 Access
 Improvement initiatives.

Defining Program Operations and Policy

The continued participation of many of the Task Force members and the knowledge and expertise that they bring will be important as the program design is refined, and during the implementation of the new program. PHSKC should convene an Operations and Policy Committee to assist staff in moving the program from the drawing board to the field. Among the issues the Committee will address, the following are particularly important:

- Guiding the Children's Health Initiative to ensure the initiative meets programmatic goals and financial guidelines
- Recruiting collaborators and funding partners and articulating the roles that they will play, and
 defining how these roles fit together, including the participating health plans, Public HealthSeattle & King County, the community clinics, other primary care providers, DSHS, etc.
- Collaborating with the Puget Sound Health Alliance to promote and reward quality health care such as preventive care and improved health status
- Identifying an overall evaluation plan and outcome measures, e.g. improvement in prevention
 and mental health that will track the effectiveness of the program in improving the ability of
 low-income families to access health care for their children

Phase 3: Coordinating with State Children's Coverage Expansions

The Task Force recommends continued collaboration and coordination with state efforts to cover all children by 2010. It is the intention of the Task Force that program features of interest to the

state could be piloted in the King County program. Consequently, evaluation activities will be critical for the County initiative to demonstrate value for the state process.

Next Steps

As the implementation planning moves forward, the Task Force proposes that Task Force staff continue to finalize the programmatic and financial information necessary to move the proposed program through King County's decision-making process. As stated above, staff should stay in close communication with the Governor's Office and other state leaders to ensure that the King County program creates a strong foundation for future initiatives to expand health care coverage for low-income children.

ENDNOTES

ⁱ 2004v3M Washington State Population Survey.

ii Institute of Medicine (IOM). 2002. Health Insurance is a Family Matter. Washington, DC: National Academy Press.

iii Forest, Christopher and A. Riley. September/October 2004. "Childhood Origins of Adult Health: A Basis For Life-Course Health Policy." *Health Affairs* 23 (5): 155-164.

iv Rosenbach, Margo, C. Irvin, R. Coulam. 1999. "Access for Low-income Children: Is Health Insurance Enough?" *Pediatrics* 103 (6): 1167-1175.

^v Fiscal Year 2004 Medicaid Utilization Report.

^{vi} 2005 Year End Demographic Snapshot: Primary Medical Care Patients, Prepared by Tim Burak, February 23, 2006, PHSKC Community Health Center Partnerships Program.

APPENDIX A: REVISED FEASIBILITY STUDY FOR THE CHILDREN'S HEALTH ACCESS TASK FORCE *

* A draft of the feasibility study was presented to the Children's Health Access Task Force at its first meeting April 26, 2006. Since then, it has been updated to reflect new information and data.

King County Children's Coverage and Access Program Analysis for the Children's Health Access Task Force

Executive Summary

- Approximately 16,000 children have no health insurance in King County. Of these children, an estimated 15,000 are living in families with income below 400% of the federal poverty level (FPL)—about \$51,320 for a family of two or \$77,400 for a family of four.
- Currently, Washington State's Medicaid and State Children's Health Insurance Program (SCHIP) provide coverage to children in families with income below 200% and 250% FPL, respectively.
- Washington State has a public goal to provide health coverage to all children in Washington by 2010. See Appendix A for an overview of the state approach and a summary of what was accomplished in the 2006 Legislative Session.
- King County can assist with this goal by proceeding with an accelerated pilot project to cover all children in the county before the state deadline of 2010.
- Early county implementation of a program of children's coverage and improved access to services will improve the health of King County children and families, and could inform state programs by collecting health outcome and access measures.

Next Steps

- King County can explore the feasibility of a county-based health coverage program for the relatively small number of children who are low-income and not eligible for existing publicly funded health programs.
- King County can consider the implementation of a county-wide access improvement program for all low-income children that uses culturally competent community health educators and case management to assure that children are linked to health care homes and provided with comprehensive preventive services.
- Evaluation and cost-effectiveness measures will be critical to the value that could be provided by these King County programs.
- Staff recommendation is to develop a county-funded Children's Health Initiative program starting in July 2006 using a task force to assist with program design. It is expected that County funding would segue into state funded coverage as the statewide child health insurance expansions proceed in 2008, 2009 and 2010.

Appendix A/1

Health Care for All Children in King County

To make a difference in children's health, it is essential to have both health care coverage and a health care delivery system that is ready to provide early preventive services and link children to needed care. This is a key lesson learned as states such as Vermont and California have embarked on initiatives to improve the health of children.

King County has a unique opportunity to create a program to provide health insurance coverage and access to children currently without health insurance in partnership with the State of Washington, which has declared an intention to cover all children in the state by 2010. The purpose of this feasibility study in 2006 is to document the scope of the problem of children without health insurance in King County and to research King County's options and the costs, potential savings, benefit package modeling, delivery system linkages and enhanced prevention services necessary to pilot an expansion of health coverage and access to all children living in King County. This proposal aims to reformulate social policy so that outreach efforts can use the simple message that all children are eligible for health insurance and need preventive care. Rather than having families navigate complicated health coverage programs, eligibility workers will work behind the scenes to determine which program the children qualify for and systems will be in place to connect children to services.

While local county support can demonstrate that such an approach is feasible, in the long run state and federal policy changes are needed to sustain the coverage expansion. This approach should fit well in King County and Washington State, since there is a state commitment to covering all children statewide by 2010.

I. Problem

An estimated **16,000** (4% of all children in King County) have no health insurance, according to 2004 survey data.

Half of the 16,000 uninsured children are eligible for existing programs, Medicaid, State Children's Health Insurance Program (SCHIP) or Basic Health Plan coverage (See bar graph on page 4). Medicaid covers about 460,000 children statewide below 200% FPL, except undocumented immigrant children. However, about one quarter of these children can enroll in a new state-funded Children' Health Program which provides limited coverage. As federal Medicaid rules requiring citizenship documentation are implemented starting 7/1/06, more immigrant children are expected to be ineligible for Medicaid. SCHIP covers about 11,000 children statewide from 200% to 250% FPL, and excludes immigrant children. Basic Health covers about 15,000 children up to 200% FPL, with limited benefits, e.g. no dental or physical therapy and substantial cost sharing. The complexity of current eligibility rules is a barrier to families trying to obtain health coverage for their children.

Approximately 4,000 children in King County families with incomes over 250% are not eligible for public coverage. Some of the job of covering all kids consists of providing outreach and enrollment assistance so families with incomes under 250% FPL know about and enroll in coverage that is available to them. In order to truly cover "all" children in King County, a new

Appendix A/2

county-funded health care coverage program would have to be created to make coverage available to children in families with incomes over 250% (4,000 potential children) and to most immigrant children (3,000 to 5,000 children below 250%).

8,000 **Uninsured children** 7.000 6,000 4,000 3,000 3,000 2,000 2,000 1,000 less than 100-200% 200-250% 250-400% more than 100% FPL 400% Medicaid and **SCHIP** BHP coverage

Chart 1. Uninsured children by family income level in King County, 2004

<u>II. Bearing the Costs (Qualitative and Quantitative) of Children Uninsured or Unable to Access Care</u>

- Some children who do not have health insurance coverage go without care, and the consequences of this affects health status in the short- and long-run. (Illinois Report, p. 5 and WA State OFM, "Why cover children?" September 2005)
- Children without health insurance eventually receive care from emergency rooms or other safety net providers, where the cost of care is often greater than it would have been if these children had received preventive care or early treatment for a health problem. (Illinois Report, p. 5)
- Even with Medicaid coverage, access problems exist. For example, only 29% of children with Medicaid under age five in King County received any dental services in 2004.
- Seattle Children's Hospital provided \$6.8 million or 2.2% of revenue in charity care in 2002. In San Mateo County, California, the Child Health Initiative program was associated with a 58% decline in uninsured hospital stays for children in nearby hospitals. (San Mateo CHI evaluation).
- The Public Health-Seattle & King County clinics provided about 3,000 primary care visits to 1,900 uninsured children in 2005 at a cost of approximately \$550,000. A rough analysis of King County safety net data shows the community health centers in King County provided care to an additional 7,000 to 9,000 uninsured children in 2005 and bore the resulting costs.

Appendix A/3

- Employers bear absenteeism costs when parents must stay home to care for their children.
- Poor child health has a negative effect on both the mother's and the father's employment chances, reducing the likelihood of working by 8 percentage points, for each. (*Fragile Families Research Brief*, Center for Research on Child Wellbeing, 2004)
- The real costs of uninsured children far exceed the costs of providing coverage. These costs include costs for inappropriate or mistimed treatment, lost parental work days, lost days in school, and late behavioral and developmental interventions over the course of a child's first 18 years. (IOM, *Hidden Costs*, *Value Lost: Uninsurance in America*. Washington DC: National Academies Press, 2003.)

III. Advantages (to the child and to society) of Improving Access and Coverage for Children

- Insured children have better access to medical homes or regular source of care, and through medical homes better access to appropriate and timely prevention, detection and care (Institute of Medicine, Health Insurance is a Family Matter, 2002, and Children's Health, the Nation's Wealth: assessing and Improving Child Health, 2004, and Child Health Business Case Working Group, 2004, "Exploring the Business Case for Improving the Quality of Health Care for Children," *Health Affairs* 23 (4): 159-166.).
- The California Health Status Assessment Project found that children who were enrolled in health insurance improved their school performance ("paying attention in class" and "keeping up with the school activities") by 68 percent (IL Report).
- Missouri's Children Health Insurance Program found its program decreased school absences by 39 percent (IL Report).
- Early and consistent dental care can reduce future dental treatment and expenses for children (Savage, *Pediatrics* 2004).

IV. State's Plan to Cover All Children

• Governor Gregoire and a number of State Senators and Representatives (Democratic Caucus, Rep. Judy Clibborn, Rep. Eileen Cody, House Speaker Frank Chopp and others) have a stated goal to cover all children by 2010. (See **Appendix A/7**).

Appendix A	1 /4	

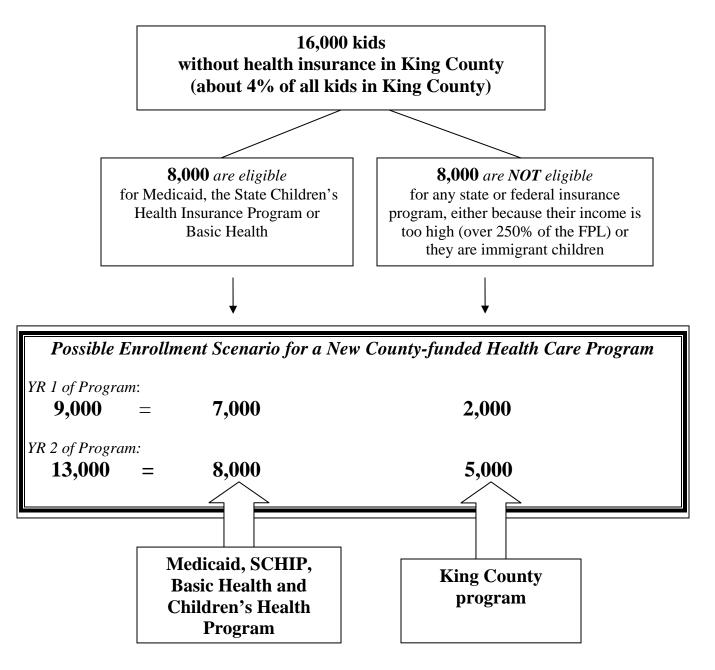
V. Projected Costs of Covering All Kids in King County

Projected costs for a county-funded health insurance program will be developed by Milliman Consultants and Actuaries under contract to King County. In addition, cost projections will need to be developed for improved outreach, community health education, case management and evaluation activities. The outreach campaign will rely on community resources to reach eligible families and the access assurance activities are intended to support a well-organized delivery system that assures that all children have a health care home (medical and dental) and that comprehensive preventive services are delivered, based on lessons learned from Kids Get Care.

For initial estimates of health care coverage costs and enrollment trends, we can look to counties in California, specifically San Mateo County (more information at www.ihps-ca.org). San Mateo County administered a health insurance program for children up to 300% of FPL, and other California counties have created Child Health Initiatives to cover all children up to 300% FPL. We also can look to San Mateo County for estimates for outreach, administrative, evaluation and improved delivery system costs that will benefit the entire county. The linking, coordinating and measuring activities will assure that families know coverage is available, that they enroll, and once enrolled, that they receive timely and appropriate care.

King County has the opportunity to demonstrate national leadership in providing coordinated health coverage for all children ahead of the state goal of 2010. Providing comprehensive medical, dental and behavioral coverage and services to all children in the county can be accomplished for a financial amount that is not out of reach for our region. With universal coverage and a well-organized safety net delivery system, King County can document the health and social benefits of assuring that all children have the chance to grow up to reach their highest potential.

Diagram of State/Feds vs. County Enrollment and Direct Costs of Providing Health Care



Appendix A

<u>DRAFT</u> – STATE PLAN TO COVER ALL KIDS BY 2010 - <u>DRAFT</u> - November 22, 2005

Every parent should know how to get, be able to afford, and have access to health care for their children. Once covered, every child should have a "health home" with access to well-child and preventive services.

Seek system reform and reduce administrative barriers to coverage and care.

2005 Session/ Exec. Actions	6% 2005 interim	5% - 82,000 2006	4% – 66,200 2007	3% - 50,000 2008	2% - 33,600 2009
Executive/ legislative action in 2005 session: 1) Return to 12 month continuous eligibility; and 2) Reauthorization of Children's Health Program; Should provide coverage for an additional 35,000 children by June 2007. 2004 rate of uninsured children was 5.8% – 95,646.	1) Culture of outreach. 2) Centralized application MEDS. 3) Pursue outreach partnerships with schools. 4) On-line apps. 5) Allow eligibility screening by CBO's. 6) Develop "health home" and children's health performance measures. 7) Federal action: SCHIP match rate for Medicaid kids; Title XXI waiver for coverage of parents.	1) Outreach funding in budget; targeted outreach via CBO's; coordinated development and distribution of materials. 2) Budget proviso directing agency action noted as in 2005 interim. 3) Prohibit premiums at or below 200% FPL, by statute. 4) Link between parent and kids' coverage – consider increased BHP slots. 5) Reimbursement issues, i.e. HO trend and performance-based payment in 2007 HO contract.	1) Increase slots for immigrant kids; 2) Further develop and implement "health home" and other childrens' health performance measures; 3) Address children's oral health and mental health access issues, and improve care for children with chronic conditions.	1) Increase immigrant kids' eligibility to 200% FPL. 2) Continue work on items # 2 and # 3 from 2007.	1) Increase SCHIP eligibility. 2) Continue work on items # 2 and # 3 from 2007.
	System reforms	System reforms	System reforms	System reforms	

NOTE: Future rate/number goals should factor in population growth. Public coverage goals would consider potential reduction in employer sponsored coverage of dependents, and increasing number of children under 250% FPL as wage increases lag behind inflation. In 2004, 70% of uninsured kids had family income below 250% FPL. Numeric goals are based on OFM population estimates

APPENDIX B: TASK FORCE MEMBER INVITATION LETTER FROM EXECUTIVE SIMS

Dear Child Health Expert:

We know approximately 16,000 or 4% of all children in King County do not have health insurance or have access to basic health care services. We know that access to early preventive health care services can profoundly affect the trajectory of a child's health and well-being and readiness for school. We know that children with insurance coverage are more likely to be able to access needed services and we know that it is less costly to pay for prevention than to pay for acute health care.

I commend Governor Gregoire for her pledge to cover all children in the state by 2010. I would like your help to assist the state coverage goal by exploring the creation of an innovative county-based Child Health Insurance program for all currently uninsured immigrant and non-immigrant children in King County, who are not eligible for state programs. Early county implementation of an innovative program could inform state programs by piloting innovative strategies. This approach has been successfully implemented in 18 California counties since 2001, and the first California counties were in fact motivated by innovative access approaches here in King County, including the Kids Get Care program.

Given your expertise and knowledge about health in general and child health issues, I would be delighted if you would serve on the King County Children's Health Access Task Force (CHATF). The purpose of the CHATF is to build upon the foundational work of the King County Health Action Plan and help develop the specific steps to provide coverage and access for all uninsured children in King County. My initial thoughts on specific requests of the Task Force include the following:

- Finalizing the design of a gap insurance program that would be offered to families of children who are not eligible for existing public or private programs.
- Reviewing actuarially sound model options to be presented
- Drafting a charter that lays out the Task Force's vision for a county-based child health coverage and access program
- Specifying an approach for improving the mechanisms and measures that assure that children in King County obtain preventive medical, dental and behavioral services
- Drafting an RFP for a health plan(s) to contract with the county to provide health care coverage for uninsured children ineligible for public programs

The time commitment to serving on the CHATF will be minimal, although the advice and direction we receive will be invaluable. I believe three meetings during April, May and June is sufficient to successfully launch this effort. It is my goal that before the end of June – when "school is out," - that the CHATF will be ready not only to announce, but to launch this King County effort, paving the way for healthier futures for all our children in all our counties.

The first meeting of CHATF will be held on Wednesday, April 26th from 3 pm until 4:30 pm. The second and third meetings will be held on Monday, May 15th from 11 am to 1 pm and Monday, June 12th from noon until 2 pm. All CHATF meetings will be held in the Paramount Conference Room, Public Health – Seattle & King County, on the 12th floor of the Wells Fargo Building (999 Third Avenue, Seattle). You will receive meeting materials prior to the first meeting.

I do hope you or an expert on your staff is able to lend your expertise to this effort. Your agreement to serve on the King County Children's Health Access Task Force will be an investment in time that can truly affect generations in just a few months. Please RSVP to Rachel Quinn, Health Policy Liaison, if you or someone from your organization will attend one or all of the CHATF meetings. Rachel can be reached at 206-296-4165 or rachel.quinn@metrokc.gov.

I look forward to meeting with you on April 26th and working with you to assure health care coverage and access to services for all of the children in King County.

Sincerely,

Ron Sims King County Executive

ACTUARIAL COSTS OF THE MEDICAL	APPENDIX L AND DENTAL	ELS BY MILLIMA	AN, INC.



Exhibit 1

King County - Children's Health Initiative Medical Rate Development Calendar Year 2007 Baseline Plan Design

		(1)	(2)	(3)	(4)	(5)	(6)	(7)
Benefit		ation Per	Allowed Average Charge	Per Member Per Month Claim Cost	Copay Utilization	Copay	Per Member Per Month Cost Sharing Value	Per Member Per Month Net Claim Cost
Hospital Inpatient	51.4	Days	\$2,929.96	\$12.55				\$12.55
Hospital Outpatient		,						
Emergency Room	202	Cases	\$283.37	\$4.77	202	\$25.00	\$0.42	\$4.35
Other	245	Cases	379.59	7.75				7.75
Physician								
Preventive	1,006	Services	\$43.54	\$3.65			\$0.00	\$3.65
Outpatient Psychiatric / Substance Abuse	244.0	Visits	82.62	1.68	244.0	15.00	0.31	1.37
Other Physician	5,325	Services	56.83	25.22	2,010	15.00	2.52	22.70
Other								
Prescription Drugs	3,688	Scripts	\$49.36	\$15.17	3,688	\$2.86	\$0.88	\$14.29
Other	121	Services	188.43	1.90			0.00	1.90
Value of Preexisting Condition Exclusion				(\$3.63)			\$0.00	(\$3.63)
Total Medical Cost				\$69.06			\$4.13	\$64.93
Administration (15%)								\$11.46
Total Cost								\$76.38
Notes:								

- Assumes provider reimbursement and degree of healthcare management comparable to the Washington SCHIP program.
- Benefit limitations and member cost sharing:
 - No cost sharing for preventive services
 - \$15 office visit copay
 - \$25 emergency room copay
 - \$10 copay on brand name drugs, no copay on generics
 - Psych limitations of 30 inpatient days and 24 outpatient visits
 - Pre-existing condition waiting period of 9 months for select conditions
 - Dental benefits not included
- Assumes coverage up to 300% FPL with minimal member premium requirements

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Exhibit 2

King County - Children's Health Initiative Medical Rate Development Calendar Year 2007

Low Cost Sharing Option

		(1)	(2)	(3)	(4)	(5)	(6)	(7)
Benefit		ation Per	Allowed Average Charge	Per Member Per Month Claim Cost	Copay Utilization	Copay	Per Member Per Month Cost Sharing Value	Per Member Per Month Net Claim Cost
Hospital Inpatient	51.4	Days	\$2,929.96	\$12.55				\$12.55
Hospital Outpatient								
Emergency Room	238	Cases	\$283.36	\$5.62				\$5.62
Other	245	Cases	379.59	7.75				7.75
Physician								
Preventive	1,006	Services	\$43.54	\$3.65			\$0.00	\$3.65
Outpatient Psychiatric / Substance Abuse	268.0	Visits	82.39	1.84			0.00	1.84
Other Physician	5,915	Services	55.48	27.35			0.00	27.35
Other								
Prescription Drugs	3,820	Scripts	\$49.35	\$15.71	3,820	\$2.86	\$0.91	\$14.80
Other	121	Services	188.43	1.90			0.00	1.90
Value of Preexisting Condition Exclusion				(\$3.82)			\$0.00	(\$3.82)
Total Medical Cost				\$72.55			\$0.91	\$71.64
Administration (15%)								\$12.64
Total Cost								\$84.28
Notes:								

- Assumes provider reimbursement and degree of healthcare management comparable to the Washington SCHIP program.
- Benefit limitations and member cost sharing:
 - No cost sharing for preventive services
 - No office visit copav
 - No emergency room copay
 - \$10 copay on brand name drugs, no copay on generics
 - Psych limitations of 30 inpatient days and 24 outpatient visits
 - Pre-existing condition waiting period of 9 months for select conditions
 - Dental benefits not included
- Assumes coverage up to 200% FPL with no member premium requirements

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Exhibit 3

King County - Children's Health Initiative Dental Rate Development Calendar Year 2007

TT 141		
Utilization	Average Charge	PMPM
1,806	\$27.46	\$4.13
1,744	29.14	4.24
1,096	20.26	1.85
1,459	13.56	1.65
6	27.81	0.01
172	22.35	0.32
7	\$30.93	\$0.02
14	99.64	0.11
202	54.68	0.92
146	133.99	1.63
12	140.05	0.14
55	104.15	0.48
1,281	62.28	6.65
12	56.26	0.06
71	102.41	0.61
68	\$170.34	\$0.97
0	424.29	0.00
2	291.24	0.05
0	24.86	0.00
0	77.45	0.00
6,283	\$140.58	\$12.20
1,800	784.38	10.61
70	988.18	1.01
8,153	\$35.07	\$23.83
		\$4.20
		\$28.03
	1,806 1,744 1,096 1,459 6 172 7 14 202 146 12 55 1,281 12 71 68 0 2 0 0 0 6,283 1,800 70 8,153	1,806 \$27.46 1,744 29.14 1,096 20.26 1,459 13.56 6 27.81 172 22.35 7 \$30.93 14 99.64 202 54.68 146 133.99 12 140.05 55 104.15 1,281 62.28 12 56.26 71 102.41 68 \$170.34 0 424.29 2 291.24 0 24.86 0 77.45 6,283 \$140.58 1,800 784.38 70 988.18 8,153 \$35.07

Notes: - Provider reimbursement based on Washington Medicaid fee schedule, including ABCD add-on fees.

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⁻ Assumed utilization includes a load for first-year dental coverage.

⁻ No member cost sharing

⁻ Excludes orthodontia services.

APPENDIX D:

TASK FORCE MEETING AGENDAS AND MINUTES

- Meeting #1: April 26, 2006
- Meeting #2: May 15, 2006
- Meeting #3: June 12, 2006

King County Children's Health Access Task Force

Meeting #1 April 26, 2006

Meeting Minutes

Task Force members

Co-Chair Maxine Hayes, Washington State
Department of Health - Present
Co-Chair Ben Danielson, Odessa Brown Children's
Clinic - Present
Dale Ahlskog, Molina Health Care of WA - Present
Teresita Batayola, International Community Health
Services - Present
Jane Beyer, WA State House of Representatives Present
Chris Bushnell, King County Budget Office - Present
Bob Cowan, King County Budget Office - Absent
Laura Cox, Center on Budget and Policy Priorities Present
Bob Crittenden, Harborview - Present

Darnell Dent, Community Health Plan of WA - Present
Charissa Fotinos, Public Health-Seattle & King County - Present
Christina Hulet, Governors Office - Absent
Tracy Garland, WA Dental Foundation - Present
Leo Greenawalt, Washington State Hospital
Association - Absent
Paola Maranan, Children's Alliance - Present
Suzanne Petersen, Children's Hospital - Present
Dorothy Teeter, Public Health-Seattle & King
County - Present
Greg Vigdor, Washington Health Foundation -

Staff and Guests

Ron Sims, King County Executive
Judy Clegg, Clegg & Associates
Susan Johnson, Public Health-Seattle & King County
Rachel Quinn, Office of King County Executive
Kirsten Wysen, Public Health-Seattle & King County
Penny Reid, Washington Health Foundation
Liz Arjun, Children's Alliance
Jerry DeGrieck, City of Seattle

Rebecca Kavoussi, Community Health Plan of WA Melissa Waddell, Washington State Hospital Association Tim Barclay, Milliman Actuaries Paula Holmes, Odessa Brown Children's Clinic John Amos, King County Budget Office Hall Walker, King County Budget Office Desiree Leigh, Children's Hospital

Welcome & Introductions

Dorothy Teeter welcomed the Task Force on behalf of Public Health–Seattle & King County to its first of three meetings. She commended King County Executive Ron Sims for his leadership and passion for health care issues as well as his impatience to find solutions to health care problems.

Absent

Teeter then introduced co-chairs, Dr. Maxine Hayes and Dr. Ben Danielson. Dr. Hayes welcomed the task force. She expressed excitement that talented individuals such as Task Force members have chosen to "roll up their sleeves" and start working out solutions to the uninsured child problem. She also thanked the Executive for the opportunity to be involved in this effort. Danielson echoed Hayes' sentiments. He thanked Executive Sims for convening a great group of people who can put forth some expertise and ideas. This Task Force is a chance for finding tangible outcomes.

Task Force members introduced themselves.

Executive Sims thanked the co-chairs for agreeing to serve, and thanked staff for their work and for being strong advocates for pushing this issue forward. He then stressed the importance of this issue and of going beyond talk to action. He doesn't want to read any more articles or reports on the subject because every

story ends with the same lament that children are still uninsured. Executive Sims believes there is fertile ground for King County Staff to plow ahead, to act, to move forward to implementing solutions instead of talking about the problem.

Executive Sims' expectations are simple: tell him how King County can provide health coverage to uninsured children in King County. King County has hired Milliman Actuaries and Consulting to do the cost analysis. Executive Sims closed with his strong belief that we can provide children with the health care they need in King County

Co-chairs Dr.'s Hayes and Danielson shared why they agreed to serve as co-chairs. Dr. Hayes stated that she has been privileged to able to work previously with Ron Sims on a lot of health issues. Governor Gregoire is committed to covering all kids by 2010. Kids Get Care has shown how to get preventive services to children, but we spend a lot of time and energy with eligibility hurdles that still keep kids out of the programs we know can help them. The message should be, "let's say our kids are covered." It's a doable goal. The numbers of children and the costs aren't that big.

Dr Danielson added he is honored for the opportunity to co-chair the task force, to be at this table and to put some real work into creating solutions. Danielson said he is on front line delivering services to children and it's frustrating to see the problems getting worse not better during his seven years in practice. This Task Force is our chance to do something tangible and be a pilot and demonstration for a state wide program. It is his job to help the Task Force members do some great work.

Dorothy Teeter turned the meeting over to Judy Clegg, Clegg & Associates, the meeting facilitator. Clegg facilitated the King County Health Advisory Task Force in 2004 and 2005 which resulted in the creation of the Puget Sound Health Alliance. Clegg introduced Susan Johnson, Director, King County Health Action Plan.

Ms. Johnson gave a quick background to past health care efforts. She expressed excitement and readiness to build upon the work of past efforts. There is a goal of 2010 before us, and we have an incubator to try bold ideas that are affordable and doable. These themes of leadership, vision and partnership are replicable and can be shared with other counties.

Clegg reviewed the goals of child health program:

- Design a health coverage program that fills gaps so all kids are covered
- Create a replicable pilot that combines coverage and access improvements
- Don't break the bank
- Keep it simple!

Wysen distributed three handouts outlining benefit design and eligibility for the four current state programs: Healthy Options (HO), WA SCHIP, Children's Health Plan (for immigrant children), and the WA Basic Health Plan (BHP) as well as a fifth program to be developed by this group, the King County Children's Gap Program. Wysen explained staff created this program as the "strawperson" for the Task Force to react to and build their recommendation for Sims. The King County Gap Program is based on the features of Healthy Options and Medicaid programs. Tim Barclay, the Milliman actuary, will then analyze the costs and conduct sensitivity tests associated with the Task Force's recommendations.

Benefit Design Discussion

Medical – medically necessary medical benefits (same as Healthy Options)

Task Force comments: There was discussion that the benefit design should be comprehensive since kids enrolled in the gap program will have higher incomes and be able to afford better care. It was noted,

though, that we need to be cautious and be cognizant of crowd out issues and the potential of crowding out private coverage.²

 Dental – medically necessary dental services, through the Children's Dental Program (same as Healthy Options)

Task Force comments: Dental under Medicaid is a carve-out option and offers very limited orthodontia coverage. Basic Health Plan doesn't offer dental. If the County offered a dental package alone, BHP children may sign up. It was noted, however, that there aren't that many children enrolled in BHP.

 Vision – medically necessary services and hardware. Eye exams through the health plan, hardware through state contractor (same as Healthy Options)

Task Force comments: Vision is a carve-out option under Healthy Options. There's a limited benefit of the number of glasses a person can get (1 pair every 12 months), but it's considered adequate coverage.

■ Mental health – 12 outpatient visits/30 inpatient days

Task Force comments: Additional services available through referrals to Regional Support Networks (RSNs) if kids meet the access to care criteria at least. Twelve visits seem very limited and minimal, 24 visits was suggested as an alternative. This is a factor that will be included in the actuarial pricing model.

Substance abuse services – Through Division of Alcohol and Substance Abuse (same as Healthy Options)

Task Force comments: Kids' substance abuse and mental health problems are linked because mental health problems most likely resulted from family mental health and/or substance abuse issues. Substance abuse services are carved out benefits and handled by the State Department of Alcohol and Substance Abuse (DASA).

Follow up Items for Staff:

 Research what California's experience has been with mental health and substance abuse coverage and cost

Cost sharing

Monthly premiums - use a sliding scale, based on income and ability to pay

Task Force comments – The Task Force overall agreed premium levels should be set between the premium levels under SCHIP and BHP. However, some Task Force members expressed concern over the impact of premiums and causing disenrollment. Families are very sensitive to premium levels. A premium that is not affordable could cause disenrollment. Many members pointed out there are administrative costs to processing premiums and most of the premium collected will go towards the administrative costs. Some voiced concern of setting premiums too high thereby creating access to care concerns and cited other state experiences in Rhode Island and Oregon. Those states saw a large disenrollment when a premium was applied to families well below poverty. On the other hand, others showed concern for crowd out issues if no premiums are imposed. Setting premiums too low could create crowd out issues causing families to drop their employer-based insurance. Staff reinforced this is a gap program so we need to find a middle ground.

■ Deductible – None

Task Force comments – no discussion.

Preventive visits – None

Task Force comments – no discussion.

Office visits – model \$0, \$5 and \$15

Task Force comments – A \$5 co-pay is in place in many of the California county programs. Some Task Force members believed there should be no co-pays because children are going to be served regardless of their ability to pay. We should do a cost recovery on the premium side rather than the co-pay side. As with the premiums, the program should be kept simple and affordable because there are administrative

² Crowd out issue is the result of offering a package that causes currently covered persons to drop employer coverage to join in a plan that is more favorable, less costly or both

costs to think about, and providers do not make much off of the co-pay. A member of the Task Force offered to research what the various clinics in Seattle offer as a sliding fee scale for office visits. Staff will follow up. Expression was offered that it would be nice to partner with a county on the east side of the state to have a variety of "incubators" testing models of coverage and access elements

Outpatient, lab, radiology, etc. – None

Task Force comments – no discussion.

Inpatient hospital – None

Task Force comments – no discussion.

■ ER visit - \$25 co-pay

Task Force comments – no discussion.

Prescription drugs - \$5 brand name, \$0 generic

Task Force comments – no discussion.

■ Out-of-pocket limit – None

Task Force comments – no discussion.

 Others – A question was asked whether maternity benefits were considered to be included in the benefit package. Since "medically necessary" benefits are covered, maternity coverage would be included if a member needed such services.

General comments during benefit design discussion: The strawperson program looks very similar to Healthy Options. A program like Healthy Options looks like it fits the Task Force's intent.

Follow up items for staff:

- Staff was directed to research premiums and co-payment levels in the San Mateo and other California counties.
- It was noted that rules for non-payment of premium and re-enrollment will need to be developed. The initial inclination is to mimic Basic Health Plan's rules.
- Also note that renewal rules will be needed. Staff will collect studies and experience with various renewal approaches, including passive renewal with random audits(a postcard is sent to enrollees each year with a request to the enrollee to submit information about changes, a sample of enrollees have to submit updated documentation), active renewal (new income documentation paperwork is required every year, for example) and frequency (6 month vs. 12 month)

Eligibility Discussion

■ Age – up to 19

Task Force comments – The general definition of a 'child' is through age 18. Up to age 19 will help replicate program state wide.

Residency – King County residents, and use same proof of residency required for Medicaid and the Basic Health Plan.

Task Force comments – Keep the residency requirements and proof of residency simple to avoid creating barriers and spending a lot of energy to deeming kids eligible.

■ Income – Model 300%, 350% and 400%.

Task Force comments – Task Force members felt comfortable with a higher income. It's hard to imagine that those with money are not choosing insurance based on an inability to pay. Another suggestion was to have no income limit and then have a premium scale kick in at the higher incomes. This way the program would have a good case mix of kids. Many agreed this is a good idea to cost out.

• Other eligibility rules – uninsured children ineligible for other public health care coverage.

Task Force comments – no discussion.

Crowd out protection

Task Force comments - The basic design of the program needs to build in incentives for people to stay where they are so it would not encourage to dropping current coverage.

Pre-existing condition waiting period – was not discussed. This issue will be discussed at the 2nd Meeting.

General comments during eligibility discussion:

- One suggestion was to build centers of excellence and quality of care components into the care delivery strategy. Because this is a county program is going to attract kids with severe health problems it is inevitable some providers will choose not to provide care to this population. This is a cost and quality of care issue. Maybe there are some potential linkages with the Puget Sound Health Alliance.
- Washington State is now looking at subsidizing some insurance costs for small businesses. This Task Force needs to be aware of this strategy.
- It's a moral statement to say all kids are deemed eligible and we have this opportunity to do this now. This is an important time. We need to question why we are so scared about designing something "too good" for children. We should develop a range of options to consider from the simple to the more radical.

Follow up items for staff:

• Research California's experiences with crowd out issues.

Access

The Task Force had a general discussion about access strategies. Staff explained the need to discuss access to care since enrollment and access issues are intertwined. Wysen explained a hand out outlining proposed access strategies (e.g., community health educators, outreach workers, case managers/care coordinators).

Task Force comments:

- One idea is to build access infrastructure costs into the premium (e.g., analogs to the Access to Baby and Child Dentistry (ABCD program)). It would helpful to get an estimate from staff on the ratio (provider to patient), costs, and impact of staff.
- In terms of identifying uninsured kids and getting them enrolled, providers seem to be the most logical person/strategy.
- A Task Force member asked a question about capacity, where are enrollees in current state programs being served and is care evenly distributed among providers.
- There are problems with the specialty providers and reimbursement seems to be the root cause of the problem. Other members point out it may not be a financial issue.
- Access to care strategies need to go beyond private clinics to community health centers.
- Most of our target population is made up of people who are not known to the health care system. They have not accessed the system. These children need to be reached before they enroll/seek health care services. Recommend venues: child care centers and schools.
- Exploration needed for incentives for centers of excellence and care delivery improvement.
- Option for County to tie in some incentives with its current contract with Aetna should be explored.

Follow up items for staff:

- Research costs associated with analogs to ABCD.
- Research diverse models that would fit in multiple settings.

Meeting adjourned at 4:40 pm. Next meetings, same location: Monday, May 15, 11:00am- 1:00pm and Monday, June 12, noon-2:00pm.

King County Children's Health Access Task Force

Meeting #2 May 15, 2006

Meeting Minutes

Task Force members

Co-Chair Maxine Hayes, Washington State Department of Health - Present

Co-Chair Ben Danielson, Odessa Brown Children's Clinic - Present

Dale Ahlskog, Molina Health Care of WA - Present Teresita Batayola, International Community Health Services - Present

Jane Beyer, WA State House of Representatives - Present

Chris Bushnell, King County Budget Office - Present Bob Cowan, King County Budget Office - Present Laura Cox, Center on Budget and Policy Priorities -Present Bob Crittenden, Harborview - Absent Darnell Dent, Community Health Plan of WA - Absent Charissa Fotinos, Public Health-Seattle & King County - Present

Christina Hulet, Governors Office - Absent Tracy Garland, WA Dental Foundation - Present Leo Greenawalt, Washington State Hospital Association - Absent

Paola Maranan, Children's Alliance - Absent Suzanne Petersen, Children's Hospital - Present Dorothy Teeter, Public Health-Seattle & King County -Absent

Greg Vigdor, Washington Health Foundation - Absent

Staff and Guests

Judy Clegg, Clegg & Associates Susan Johnson, Public Health-Seattle & King County Rachel Quinn, Office of King County Executive Kirsten Wysen, Public Health-Seattle & King County Penny Reid, Washington Health Foundation Liz Arjun, Children's Alliance Jerry DeGrieck, City of Seattle Rebecca Kavoussi, Community Health Plan of WA Claudia Sanders, Washington State Hospital Association Tim Barclay, Milliman Actuaries and Consulting Paula Holmes, Odessa Brown Children's Clinic Jonanthan Larson, King County Budget Office Desiree Leigh, Children's Hospital Pam MacEwan, Group Health Cooperative

Welcome & Introductions

Co-chair Dr. Maxine Hayes welcomed the Task Force to its second of three meetings. She thanked the Task Force members for coming and lending their expertise, and expressed optimism for the hard work the Task Force accomplished at the first Task Force meeting the end of April.

Co-chair Dr. Benjamin Danielson then reviewed the agenda for the meeting. First, Tim Barclay from Milliman will present the price models he created based on the Task Force's directions from the first Task Force meeting. After Tim's presentation, Judy Clegg will lead the discussion on the group's reaction to the draft model over lunch.

Medical and Dental Draft Plan Design Models

Tim Barclay presented three design models:

- Two medical plans (a baseline plan and a low cost sharing option), and
- A dental plan

See CHATF meeting #2 handouts and materials for draft models.

The baseline medical plan was built assuming coverage for lower income children with family incomes up to 300% of federal poverty level (FPL) with minimal member premium requirements. This model has no cost sharing for preventive services; a \$15 office copayment; a \$100 ER copayment; a \$10 copayment on brand name drugs and no copayment on generics; 30 inpatient days and 24 outpatient visits for mental health; and a pre-existing condition waiting period of 9 months. The second model, the low cost sharing model, was built assuming coverage for immigrant children with family incomes below 200% of FPL not eligible for other public programs. This model differs from the baseline model in that there are no office visit copayments; a \$20 ER copayment; and a \$3 copayment on brand name drugs and no copayment on generics. Both models assume similar utilization trends, provider reimbursement and degree of healthcare management of the Washington SCHIP program, adjusting morbidity of this higher income population. Barclay projects utilization of these two medical programs will be 90% utilization of the SCHIP population. Costs for the Washington SCHIP program have traditionally been \$90 per member, per month.

The dental plan model assumes normal utilization with an upfront "hit" (families will seek more dental care for their children when coverage starts because it's likely they have delayed dental care due to previous uninsured status), and a Medicaid reimbursement fee schedule. The dental model does not assume extra ABCD costs. There is no cap on dental program.

Last, Barclay presented benefit alternative pricing options to show the pricing differences and pricing sensitivity of different benefit plan options (e.g., the price increase of premiums when a \$5 vs. \$0 office visit copayments).

Discussion of program design choices, benefit design, eligibility and access elements

General comments from group discussion:³

- Tiered premiums should be based on income and ability to pay, with a cap of no more than 5% of income and a cap on family premiums
- In the dental plan, the Medicaid fee schedule should be increased; outreach funds for preventive should be funded; add a cap to dental program costs
- Task Force needs to be cognizant of costs to collect/process copayments and premiums when setting copays for office and ER visits
- Type of care at office visit (e.g., care administered by a MD vs. RN, FNP, etc, secondary plan) needs to be defined
- No cost sharing below 200% of FPL
- Prevention definition should include well-child visits, chronic disease management education, and a 24 hour nurse line
- Alternative health care approaches should be considered
- Integrate mental health into provider office (link to substance abuse and dental)
- Apply ABCD model to medical plan
- Research impact of crowd out phenomenon on the commercial market

³ During the discussion the Task Force also discussed two memos included in meeting materials written to the Task Force by Bob Crittenden and Dale Ahlskog, members of the Task Force. The Task Force's responses to the memos are included in the general discussion findings.

- Foreign travel should be considered. The Task Force agreed medical care sustained abroad should not be covered
- Consider offering a separate, stand alone dental plan from medical benefits

The Task Force agreed on the following benefit design:

Benefit	Low cost model plan (<250% of FPL)	Baseline plan (250-300% FPL)
Office visits (\$0 for preventive)	\$0	\$15
ER copay	\$0	\$25
Prescription drugs	\$0 generics, \$10 brand name	\$0 generics, \$10 brand name
Mental health	Pilot innovative delivery/point of	Pilot innovative delivery/point of
	care strategy	care strategy
Pre-existing condition	Some type of waiting period for	Some type of waiting period for
	catastrophic events in order to	catastrophic events in order to
	build in risk protection for plans	build in risk protection for plans

Next Steps

Staff will take the results of today's deliberations and finalize the program design models.

The third and final Task Force meeting will be held on Monday, June 12th. At the third meeting the Task Force will discuss programmatic components such as outreach & enrollment, health education & case management, and infrastructure and miscellaneous (program administration, RFP development, technical assistance, evaluation).

Meeting adjourned at 1:00 pm.

King County Children's Health Access Task Force

Meeting #3 June 12, 2006

Meeting Minutes

Task Force members

Co-Chair Maxine Hayes, Washington State Department of Health - Present

Co-Chair Ben Danielson, Odessa Brown Children's Clinic - Present

Dale Ahlskog, Molina Health Care of WA - Present Teresita Batayola, International Community Health Services - Present

Jane Beyer, WA State House of Representatives - Present

Chris Bushnell, King County Budget Office - Present Bob Cowan, King County Budget Office - Present Laura Cox, Center on Budget and Policy Priorities -Present

Bob Crittenden, Harborview - Present

Darnell Dent, Community Health Plan of WA - Absent

Charissa Fotinos, Public Health-Seattle & King County - Present

Christina Hulet, Governors Office - Present Tracy Garland, WA Dental Foundation - Absent Leo Greenawalt, Washington State Hospital Association - Absent

Paola Maranan, Children's Alliance - Absent Suzanne Petersen, Children's Hospital - Present Dorothy Teeter, Public Health-Seattle & King County - Present

Greg Vigdor, Washington Health Foundation – Present

Staff and Guests

Judy Clegg, Clegg & Associates Susan Johnson, Public Health-Seattle & King County Rachel Quinn, Office of King County Executive Kirsten Wysen, Public Health-Seattle & King County Penny Reid, Washington Health Foundation Liz Arjun, Children's Alliance Rebecca Kavoussi, Community Health Plan of WA Claudia Sanders, Washington State Hospital Association Tim Barclay, Milliman Actuaries and Consulting Paula Holmes, Odessa Brown Children's Clinic Hall Walker, King County Budget Office Desiree Leigh, Children's Hospital Erika Nuerenberg, Office of King County Council Member Julia Patterson Mary Kate Grady, Office of King County Executive Lisa Podell, Public Health-Seattle & King County

Welcome & Introductions

Co-Chair Dr. Ben Danielson welcomed the Task Force and guests to the third and final meeting of the Children's Health Access Task Force. He congratulated the Task Force on accomplishing an incredible amount of work in the first two meetings. For today's meeting the Task Force will put the finishing touches on their proposed health insurance program for children who are not eligible for existing coverage.

Co-Chair Dr. Maxine Hayes echoed Dr. Danielson's comments and reviewed the meeting agenda. First, the Task Force will define their proposal for how outreach and access should work to ensure that families learn about and sign their children up for both existing coverage and the new King County health insurance program using a draft proposal staff have developed as a starting point. Following that discussion, the Task Force will finalize their benefit and eligibility design to ensure the design reflects the needs of lower income children and families. Once the Task Force completes their work on the designs, the Task Force will look ahead to the implementation phase – ramping up the outreach efforts during the remainder of this year and beginning the new program in January of next year. Staff has prepared a

timeline for review to understand how the program will move forward. Last, staff will give an overview of the next steps they will follow as they move our recommendations through the County's decision-making process.

Progress/Events since the 2nd CHATF Meeting, May 15th

Judy Clegg explained there has been a lot of momentum since the second Task Force meeting in May. King County Executive Ron Sims' commitment to child health and the creation of the Task Force were the centerpieces of his annual State of the County on May 22^{nd} . Reactions to his speech were very positive press as evidenced by the two editorials and two articles in the Seattle Times and Seattle PI (see meeting materials for articles). Given the positive press response, it is clear there is excitement and buy-in for the Task Force's work. The Task Force should build upon the momentum as it completes its work and program design recommendations.

Presentation of Outreach and Access Improvement Design and Task Force Discussion

Kirsten Wysen reviewed the phased plan Executive Sims outlined in his State of the County speech, in May.

- Phase 1: Outreach and Access Strategy to find and enroll children eligible for existing state programs but not enrolled (August December 2006)
- Phase 2: New gap insurance plan for low income children up to 300% of FPL and outreach and access strategy (January 2007)

Wysen then presented the outreach and access improvement draft design. This design strategy was designed to be broad but nimble. It was created based on Kids Get Care experiences, staff's collective knowledge and what research has shown to work and be effective. The draft design proposes to target areas of the County using four teams with multiple integrated efforts for 2006, 2007 and 2008:

- 1) Three half-time community health educators to train community agency staff in target areas about preventive practices, early health issues and linkage to preventive services;
- 2) Two community health workers, from within the communities of color, in each of four teams to do outreach to eligible but not enrolled children; and
- 3) One outreach worker for each of the four teams to facilitate access to insurance.

The draft design also proposes two on-site, clinic strategies for 2007 and 2008: 1) one case manager at one or multiple health care provider sites to link families to health care homes and promote preventive care; and 2) one behavioral health specialist at one or multiple health care provider sites to increase access to mental health services.

The Task Force as a whole supported the access and outreach strategies. The Task Force recommended the following additions:

- Make program culture-friendly
 - O Use "promotoras" trusted advocates of the community with already established in-roads to communities, and culturally specific educators of Asian, African-American, and Hispanic descent (with high levels knowledge in their culture and language).
 - Translate health education materials and make them user-friendly. Start with materials with unified description of program and eligibility to be used throughout the county. Materials should be 6th grade reading level or lower. Examples: DSHS fact sheet.
- Use existing infrastructure (for renewals, preventing drop-outs, etc)

- Schools, child care centers, churches, emergency rooms, and other places eligible children are likely to be. Bellevue school district is one example where it has created a cabinet of parents from very different backgrounds to reach students of all socioeconomic circumstances.
- o Use neighborhood newsletters, cultural/ethnic newspapers, etc.
- O Use web for support and to disseminate information. Healthy Mothers, Health Babies has a website full of information.
- Interim period between Present and Jan. 2007 for those not eligible for coverage
 - o Build awareness through education
 - o Keep lists of children to be covered in 2007
 - o Look into pre-enrollment
 - o Create one page document on where to go for health care in the interim period
- Ideas to improve as phase one continues
 - o Re-invent new model for outreach out in the field, target the specific population. Use specific providers to find eligible children.
 - o Combine the role of the educator with that of a broker for health care
 - o Collect research from the targeted community. Find out how best to serve the community-ideas for outreach, which providers are most supportive, etc.
- Ensure strategies are linked up with State efforts
 - o King County's efforts need to interface with the state/Medicaid agency
- Other issues to consider
 - o Renewal and Drop-outs create linkages with state agencies and providers to decrease loss of clients during renewals
 - o Address preventive care and get kids a health care home first. Show people value to keep them in program
 - o Check capacity of the Children's Health and Access Program (CHAP)
 - o Transportation (to and from medical care) is a barrier for some populations. Education such as bus schedules about where to go and how is needed

Presentation of Benefit and Eligibility Design and Task Force Discussion

Wysen also presented the benefit and eligibility draft design (two medical plans (a baseline plan and a low cost sharing option)), and a dental plan. The benefit and eligibility design models were created by Milliman based on the Task Force's direction from meetings #1 & 2. (See meeting handouts for copies of the design plans). The baseline medical plan was built assuming coverage for lower income children with family incomes up to 300% of federal poverty level (FPL) with minimal member premium requirements. The second model, the low cost sharing model, was built assuming coverage for immigrant children with family incomes below 200% of FPL not eligible for other public programs.

Task Force's comments on benefit and eligibility design draft models:

- Overall, the Task Force unanimously agreed with the draft benefit and eligibility design products.
- A Task Force member suggested using a 2-tiered premium approach for amounts 200% 300% FPL. Staff explained that the \$15 monthly premium (with a cap of \$45 for a family) was recommended for simplicity purposes since WA's SCHIP program has a \$15 premium. The State explained it has no plans to expand Washington's SCHIP program (from 250% of FPL to 300% of FPL) in the near

future. The Task Force agreed to move forward and recommend one premium, \$15 per child per month, for the new King County gap program.

- A Task Force member pointed out that the Washington State Pediatric Association and the Washington State Medical Association are currently lobbying for an increase in provider Medicaid rates. The Task Force and staff needs to be cognizant of this issue as an increase in provider rates will impact access to care for children.
- Task Force members pointed out this King County gap program is a great opportunity to pilot innovative health care home and capitation payment strategies using incentives and to create true health care improvements. The Task Force and staff should look at current practice/new approaches, the role of incentives for providers, and create an outcome-based health care program (e.g., immunizations). Providers should be held accountable for care provided to children. The King County pilot should draw upon and link to the work of the Puget Sound Health Alliance. The Task Force's strategies should align with other efforts such as the Alliance and Medicaid and need to be appealing to the State as well.

Next Steps - The Decision-making Process within King County and Implementation Planning

Now that the Task Force agreed on an outreach and access approach and a benefit and eligibility model for medical and dental plans, co-chair Danielson asked Rachel Quinn from the King County Executive's Office to explain the next steps. Quinn explained that staff will spend the reminder of June drafting the Task Force's recommendations. Draft recommendations will be disseminated to Task Force members for comment and review. Once Task Force members review the draft, staff will finalize the report, which will then be submitted to King County Executive Sims.

During summer 2006, staff will prepare the necessary budget proposal to King County Council to fund Phases 1 and 2. If approved by King County Council, Phase 1 will begin in fall 2006. Staff is envisioning two committees to assist them with the program implementation: a Policy Committee and an Outreach Committee. The Policy Committee will convene during the late summer or fall and will offer guidance on the overall implementation of the effort as well as exploration of innovative efforts that could be piloted with this program. The Outreach Committee will begin work almost immediately. The Outreach Committee's focus will be evaluating the best strategies to be used for signing children up this year for the health insurance programs for which they're eligible to make sure we make the best possible use of those efforts. If interested, Task Force members were asked to volunteer to serve on either or both committees.

Appreciations and Celebration

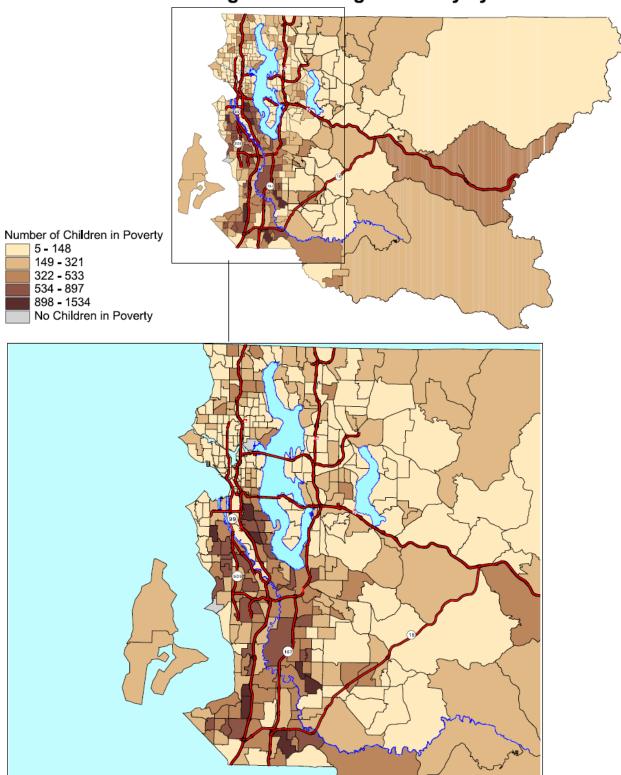
Co-Chair Hayes wrapped up the meeting by recognizing the work of each Task Force member and their commitment to this effort. As she stated previously, the Task Force has accomplished a lot of work in three meetings, but there is a lot more work to be done. As co-chairs, she and Dr. Danielson were honored that Task Force members chose to share their expertise and determination that all children should have health insurance and the access to health care that it brings. To express their appreciation, they asked each Task Force member to accept a child pin signifying their participation on the Task Force and to wear it with pride. Dr. Danielson echoed Co-Chair Hayes' sentiments. This is such an important issue- the willingness of each Task Force member to help out is so important to the improved health of the children living throughout King County.

Meeting adjourned at 2pm.

APPENDIX E:

MAP OF CHILDREN IN FAMILIES WITH INCOMES UNDER 200 PERCENT OF THE FPL IN KING COUNTY

Number of Children Ages 0-17 Living in Poverty by Census Tract



Created by Epidemiology, Planning & Evaluation, 5/06.
Poverty is defined as living at or below 200% of the Federal Poverty Level (FPL) in 1999.
Data source: US Census Bureau. 2000

APPENDIX F:

PRESS COVERAGE: MAY 23 AND 24, 2006 ARTICLES AND EDITORIALS

Sims sets new goals for children's health

County executive wants to insure 8,000 in 1st phase

BY GREGORY ROBERTS

P-I reporter

King County is in great shape – so great that county government can extend health insurance coverage to thousands of uninsured children without raising taxes, County Executive Ron Sims said Monday.

"Simply put, every low-income child, every child of the working poor, will have health insurance coverage," Sims said in his annual state of the county speech. "That so many children in this, one of the wealthiest regions in the country, go without coverage is a blot on our record

as a community."

That wealth, from a resurgent economy, has boosted government revenues to the point where the county can pay for the coverage for at least three years without raising taxes or cutting other programs, Sims said. In fact, he said, the plan might ultimately save the county money by providing children with early, preventive care that could cut down on costly, late-in-the-game treatment from the county's 10 health clinics, which spend \$3.7 million a year ministering to uninsured children.

The health insurance program was one of two initiatives highlighted by Sims in his speech. The other is the Global Warming Team, a "strike force" of county officials charged with figuring out how to cope with climate change.

mate change.

Sims, in his 10th year as the county's top elected official, cited several accomplishments of his administration, including fiscal management that has earned the county an elite credit rating, a cost-containment program for county employees' health care that has attracted national attention, major investments in parks, trails and open space, improvements in water supply and wastewater treatment systems and progress in reducing homelessness

But much of his praise was devoted to the county as a whole – its "natural advantages," its "intellectual firepower," its "robust" private sector. Indeed, Sims said, King County is one of the world's "culturally diverse and vibrant areas open to new ideas and committed to innovative technological and entrepreneurial innovations that will power our economy in this new century."

King County, he said, is "a living laboratory, a place where exciting policy experiments are perfected and then exported around the country."

His goals for the children's health insurance program are more modest: He hopes it will serve as a model in the statewide effort announced by Gov. Christine Gregoire – like Sims, a Democrat – to extend coverage to every child in Washington by 2010.

About 16,000 children lack health insurance in King County. In the first phase of Sims' initiative, the county would hire a half-dozen workers to reach out to the community and enroll the 8,000 of those children who are eligible for government coverage under federal guidelines but who are not signed up

The second phase would tackle the situation of the other 8,000 – many of them from families whose income exceeds the federal maximum for eligibility, Sims said. Some of those children come from prosperous families with parents who have decided not to acquire health insurance. But others – perhaps 4,000 – live in hard-pressed lower-middle-class families, and a task force will investigate ways to cover them, Sims said.

"There is no more obvious test of our moral fiber as a society than how we treat our most vulnerable children," he said.

On another front, Sims said he will ask the County Council to approve a transit plan that includes expanding bus service on 35 routes and creating five new rapid transit lines.

P-I reporter Gregory Roberts can be reached at 206-448-8022 or gregoryroberts@seattlepi.com.

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P-I EDITORIALS

HEALTH CARE CRISIS

County's solution

ing County Executive Ron Sims has proposed that the county ensure that "every low-income child, every child of the working poor, will have health insurance coverage." Sims' approach is particularly commendable because it is so doable.

Expanding health care coverage for children was one of two primary goals in Sims' state-ofthe-county speech to the County Council on Monday.

After the speech, Sims said he had been struck by the outpouring of public emotion and empathy for Barbaro, the racehorse that shattered its leg at the start of the Preakness Stakes on Saturday.

"That horse got exceptional health care," Sims said. "Churches were praying for him. I just want kids in King County to have the same level of care and concern."

Sims proposes tackling the county's estimated 16,000 uncovered children in two phases. The first and comparatively easier step would be to hire outreach workers to identify and recruit about 8,000 kids in the county already eligible for coverage under state and federal programs.

The second step, finding a way to fund coverage for the remaining 8,000 kids – without raising county taxes – awaits the results of the Children's Health and Access Task Force. That approach will be included in Sims' 2007 budget proposal.

When so many problems seem insoluble, it's encouraging to see one broken down into its elements and dealt with.

As Sims said, "We have the means, and now we must have the will."

The Seattle Times

Tuesday, May 23, 2006

Sims' plans include insurance for children, global warming team

By Keith Ervin

King County Executive Ron Sims said Monday he has a plan to bring medical insurance to "almost all" of the 16,000 children in the county who are uninsured.

Sims also announced, in his annual State of the County address to the Metropolitan King County Council, that he has assembled a "strike force" of top county officials to find ways to deal with global warming.

The executive said he would seek funding to hire half a dozen outreach workers who would try to enroll in Medicaid or other publicly funded insurance programs about 8,000 uninsured children who are eligible but aren't signed up.

For children who don't have federal- or state-subsidized insurance because their family incomes are above eligibility levels but whose families can't afford private insurance, Sims said after his address he will ask the County Council for money to pay their insurance premiums for the next three years.

That cost to the county to insure some of those children, he said, could be \$5 million to \$6 million. Details will be worked out by his recently created Children's Health Access Task Force.

After the three years, he said, he expects the state to provide insurance. "So many children in one of the wealthiest regions in the entire United States going without coverage is a blot on our record as a community, and we will change it," Sims said.

Sims, who previously announced several initiatives to reduce the county government's emissions of carbon dioxide and other climate-altering "greenhouse gases," said his global warming team will study changes the county must make in order to cope with climate change.

He said after his address that 57 bridges will need structural work to protect them from the fiercer winter storms that could result from climate change. He also said flood-control levees, including the Green River levees that protect low-lying parts of Kent, Renton and Tukwila, are at risk.

"People say it's not going to happen," he said of possible breaks in the levee system. "You can't say that. All you had to do was be there this past season and see it wouldn't take that much more to breach it."

If global warming results in a thinner snowpack in the Cascade Mountains and drier summers, Sims said, recycling of the region's wastewater will be needed to maintain a dwindling water supply.

Declaring that nearly all scientists now agree human activities are warming the environment, he told the County Council, "The time to defer or to delay or to deny is over."

County Council Chairman Larry Phillips, D-Seattle, praised Sims' attention to child health-care insurance and global warming.

"It's a reality," Phillips said of climate change. "There's no doubt about it."

Councilwoman Kathy Lambert, R-Redmond, said she was hopeful after Sims' address that he would support incinerating garbage to produce electricity as an alternative to burying garbage and burning fossil fuels for electricity.

Keith Ervin: 206-464-2105 or kervin@seattletimes.com



Wednesday, May 24, 2006 - 12:00 AM

Editorial Answers for 16,000 uninsured children

King County Executive Ron Sims' plan to extend health coverage to the county's 16,000 uninsured children is a smart, cost-effective idea that ought to prod similar state and federal initiatives.

The best part of Sims' plan is it doesn't require much money. Half of the county's uninsured children are already eligible for Medicaid or other publicly funded insurance programs but aren't enrolled. Six outreach workers would be hired to pair up the children with the appropriate coverage. The remaining children would have their coverage paid for by the county for three years. Then Sims expects Gov. Christine Gregoire's pledge to insure all children by 2010 to kick in.

Insuring children is the right thing to do and it is relatively inexpensive. Kids are generally healthy and their medical needs are few. But without access to health care, children's care can be costly. Things like annual well-child visits are ignored and medical treatment comes via emergency rooms.

If children are covered, it is likely King County can begin to reduce the \$3.7 million it shells out to clinics annually for uncompensated care.

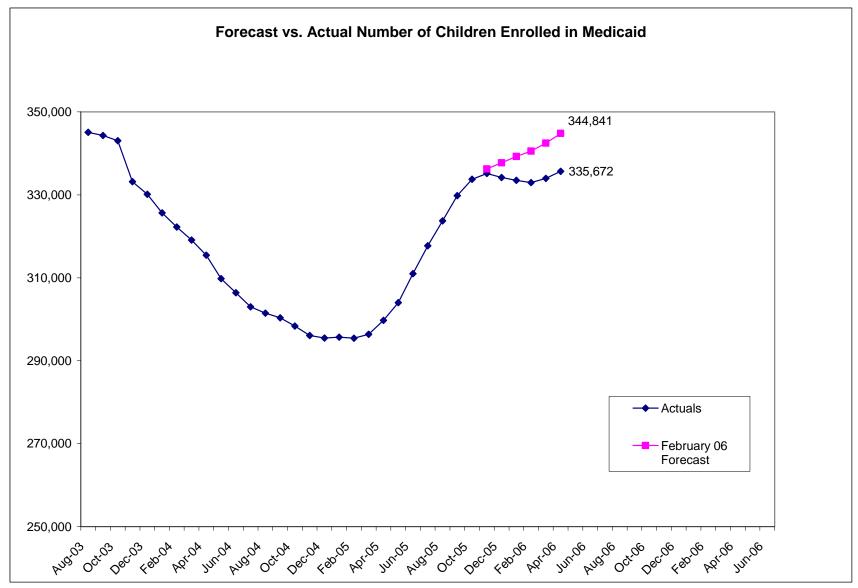
Nationwide, between 8 million and 11 million children don't have health insurance. Congress has yet to come up with a workable solution. States vary in their approach, with Washington state covering more children than most other states. Still, kids are falling through the cracks. King County doesn't propose to solve the problem, merely provide a useful catalyst for addressing it.

Many families don't know they are eligible for government-sponsored health-care coverage. The Robert Wood Johnson Foundation sponsors a national hotline; parents of noninsured children can call 877-543-7669 (877-KIDS-NOW) to determine if their children are eligible.

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APPENDIX G: WASHINGTON STATE MEDICAID CASELOAD, APRIL 2006





This chart shows the positive effect of the return to a 12-month eligibility period beginning in April 2005. From April 2005 through October 2005, the caseload steadily rose, as was expected. However, most recently however the caseload has begun to decline slightly. This chart shows the difference between the projected caseload and what the caseload has actually been. Beginning in November 2005, the number of children in the Children's Medicaid Program has been less than what was projected in the Caseload Forecast Council and points to the need for investments in outreach to find and enroll eligible children. For more information please contact Liz Arjun at 206.324.0340 ext. 21 or liz@childrensalliance.org